

Health, Welfare  
Public Service

FILED JUL 12 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

'57 STATE FILE NUMBER 21165  
2893

Registration District No. 149 Primary Registration District No. 1003 Registrar's No.

300  
-57

1. PLACE OF DEATH a. COUNTY <i>Jackson</i>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>Jackson</i>		
b. CITY (If outside corporate limits, give TOWNSHIP only) <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Kansas City</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>1867 E. 76 TERR.</i>		Length of stay in 1b <i>38 yrs.</i>	d. STREET ADDRESS (If outside give location) <i>1867 E. 76 TERR.</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>ELEANOR</i> Middle Last <i>KILANOSKI</i>			4. DATE OF DEATH Month <i>6</i> - Day <i>19</i> - Year <i>57</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>FEB. 17, 1885</i>	9. AGE (In years last birthday) <i>72</i>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, give if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>St. Joseph, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13a. FATHER'S NAME <i>Joseph O'Koniski</i>		13b. MOTHER'S MAIDEN NAME <i>Mary</i>		14. NAME OF HUSBAND OR WIFE <i>Samuel P. Kilanoski</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Miss Eleanor Kilanoski, 1867 E. 76 TERR.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ACUTE CORONARY OCCULSION</i>					INTERVAL BETWEEN ONSET AND DEATH <i>500 days</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<i>4201</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>Jan 9 55</i> to <i>Jan 19 57</i> and last saw her alive on <i>Jan 4 57</i> Death occurred at <i>11:20 p.m.</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>D. C. Quistgard M.D.</i>			22b. ADDRESS <i>6740 Prospect Ave</i>		22c. DATE SIGNED <i>6-20-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>6-22-57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem.</i>		23d. LOCATION (City, town, or county) (State) <i>Kansas City, Kansas</i>
24. FUNERAL DIRECTOR ADDRESS <i>Melody McHickey-Elyer, 1800 Linwood</i>			25. DATE RECD. BY LOCAL REG. <i>6-21-57</i>	26. REGISTRAR'S SIGNATURE <i>Neve Marshall</i>	

P. C. Quistgard  
MEDICAL CERTIFICATION  
If possible, type or print name of physician or other qualified person who attended the deceased during illness or at time of death.

All diseases in Part I must be causally related.



*Mother's Maiden Name*

*DR. Quistgaard  
6700 Prospect  
1-4 pm FRID*

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed *Melvin Bertman* .....

Licensed Embalmer No. *4903*  
P. O. Address *K C Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.